MAXIMUS Federal Services

Case Number:	CM14-0007505		
Date Assigned:	02/10/2014	Date of Injury:	02/28/2013
Decision Date:	06/24/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/21/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 57-year-old female who reported an injury on 02/28/2013 secondary to repetitive movements. The clinical document dated 12/06/2013 reported the injured worker felt better overall but continued to remain tight and stiff with radiating symptoms lessened into the arm and hand, but continued into the trapezius and upper back area. The injured worker reportedly rated her pain 8/10 which worsened with lifting, reaching, and sitting for long periods of time. The physical examination revealed moderate loss of motion of C6-T1 with stiffness and spasms of the upper trapezius, levator scapulae, and thoracic paravertebrals bilaterally. It was also noted there was a positive distraction's test. The diagnoses included cervical and thoracic sprain and strain. The injured worker underwent previous treatments to include acupuncture, physical therapy, medications to include ibuprofen, epidural steroid injections, and chiropractic care. The Request for Authorization was submitted 12/06/2013 for chiropractic manipulation treatment, massage therapy, heat, and electrical stimulation 2 times per week for 3 weeks; however, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

APPLICATION OF COLD/HOT PACKS (2) TIMES PER WEEK FOR (3) WEEKS TO CERVICAL AND THORACIC SPRAINS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Heat/cold applications.

Decision rationale: The request for application of cold and hot packs 2 times per week for 3 weeks to the cervical and thoracic sprains are not medically necessary. The California MTUS/ACOEM Guidelines state at home local applications of heat or cold are as effective as those performed by therapists. In addition, the Official Disability Guidelines recommended heat/cold applications for the neck and upper back, although there is insufficient testing to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders. The injured worker has a history of neck and back pain treated with ibuprofen, physical therapy, acupuncutre, epidural steroid injections, and chiropractic care. Within the clinical information, provided for review, it was noted the injured worker had participated in chiropractic care with the requested treatment included and she was feeling better overall. However, there is a lack of documentation noting evidence the treatment was producing objective measurable functional gains as well as any remaining functional deficits. As the request for repeat chiropractic care is not supported, the request for the application of cold and hot packs 2 times a week for 3 weeks for cervical and thoracic sprains is not supported. Therefore, the request is not medically necessary.

ELECTRICAL STIMULATION (2) TIMES PER WEEK FOR (3) WEEKS FOR CERVICAL AND THORACIC SPRAINS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The request for electrical stimulation 2 times a week for 3 weeks for cervical and thoracic sprains is not medically necessary. The California MTUS/ACOEM guidelines state physical modalities such as diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. The injured worker has a history of neck and back pain treated with ibuprofen, physical therapy, acpuncture, epidural steroid injections, and chiropractic care. Within the clinical information, provided for review, it was noted the injured worker had participated in chiropractic care with the requested treatment included and she was feeling better overall. However, there is a lack of documentation noting evidence the treatment was producing objective measurable functional gains as well as any remaining functional deficits. As the request for repeat chiropractic care is not supported, the request for electrical stimluation 2 times a week for 3 weeks for cervical and thoracic sprains is not supported. Therefore, the request is not medically necessary.

CHIROPRACTIC MANIPULATIVE TREATMENT (2) TIMES PER WEEK FOR (3) WEEKS FOR CERVICAL AND THORACIC SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Manual therapy & manipulation Page(s): 58-60.

Decision rationale: The request for chiropractic manipulative treatment 2 times per week for 3 weeks for cervical and thoracic spine is not medically necessary. The California MTUS Guidelines state manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The guidelines also state a trial of 6-12 visits over a 2-4 week period should include a formal assessment at the midway point to include documentation with evidence the treatment is producing objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The injured worker has a history of neck and back pain treated with ibuprofen, physical therapy, acupuncture, epidural steroid injections, and chiropractic care. Within the clinical information, provided for review, it is noted the injured worker has participated in chiropractic care and she was feeling better overall. However, there is a lack of documentation noting the number of chiropractic visits she has completed and evidence the treatment is producing objective measurable functional gains as well as any remaining functional deficits. Therefore, the request for chiropractic manipulative treatment 2 times a week for 3 weeks for cervical and thoracic spine is not medically necessary.

MYOFASCIAL RELEASE/SOFT TISSUE MOBILIZATION (2) TIMES PER WEEK FOR CERVICAL AND THORACIC SPRAINS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MASSAGE THERAPY Page(s): 59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Massage therapy Page(s): 60.

Decision rationale: The request for myofascial release/soft tissue mobilization 2 times a week for cervical and thoracic sprains is not medically necessary. The California MTUS Guidelines recommend massage therapy as an option with treatment adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits. The injured worker has a history of neck and back pain treated with ibuprofen, physical therapy, acupuncture, epidural steroid injections, and chiropractic care. Within the clinical information, provided for review, it was noted the injured worker had participated in chiropractic care with this treatment included, and she was feeling better overall. However, there is a lack of documentation noting evidence the treatment was producing objective measurable functional gains as well as any remaining functional deficits. In addition, the duration for treatment was not submitted within the request. Therefore, as the request for repeat chiropractic care is not supported and the duration of treatment was not submitted the request for myofascial release/soft tissue mobilization 2 times a

week for cervical and thoracic sprains is not supported. Therefore, the request is not medically necessary.